


# IT'S EASIER THAN YOU THINK



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Acrobat Reader required to view Quick Reference Guide

This e-mail newsletter, **Testing the 837**, is the third in the series *Electronic Transactions...It's Easier Than You Think*. Electronic Transactions not only make good business sense but they are also the law. Therefore, IHS is producing detailed and simple-to-use training materials to help you successfully meet the requirements for HIPAA electronic transactions and code sets. To review the previous two newsletters, [click here](#) for Newsletter #1 or [click here](#) for Newsletter #2.

The *Electronic Transactions* series includes an introductory newsletter and four topic newsletters:

- Preparing to Test the 837
- Testing the 837
- Reading 837 Error Reports and Making Corrections
- Testing and Posting the 835 Remittance

In the previous newsletter (Preparing to Test the 837) you learned how to get ready for the testing process:

- Installing the software
- Getting Implementation Guides and Addenda
- Establishing a relationship with the insurer
- Completing important forms and agreements

With this newsletter you will move through testing into production mode:

- Setting up RPMS
- Populating RPMS for error-free claims
- Completing the testing process
- Beginning production

This newsletter is particularly relevant for people in Patient Registration, Coding/Data Entry, and in the Business Office. To learn about testing the 837:

- Read this newsletter to get an overview of the topic.
- Study the accompanying [PowerPoint presentation](#) for more in-depth coverage of the topic.
- Print and keep handy the [Working With the 837 Transaction Quick Reference Guide](#) to review key information as you work.

## Overview

### Remember!

Don't submit the Trading Partner Agreement until you are ready to begin testing. The agreement may stipulate dates for beginning and completing testing.

At this point, the Business Office should have accomplished the following (see [Newsletter #2: Preparing to Test the 837](#)):

- Installed the required software modifications
- Obtained the appropriate ASC X12N Implementation Guides and Addenda
- Established a relationship with insurers, completed any required Electronic Data Interface (EDI) forms, obtained a Companion Guide, and requested a Trading Partner Agreement (TPA).

You are almost ready to being submitting electronic claims in the 837 format. However, before you can submit actual claims, you must:

- Make some modifications to RPMS (Business Office).
- Correctly enter the information needed on the 837 (Patient Registration, Coding/Data Entry).
- Test the process to make sure that it works (Business Office).

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## Set Up RPMS

The system parameters in RPMS (Resource Patient Management System) must be set up correctly or you will not be able to submit claims for the 837 transaction. This set-up involves:

- Inputting the correct provider taxonomy codes (VA Fileman New Person file)
- Inputting the correct location codes (VA Fileman Location file)
- Setting up the Location files (3P Table Maintenance)
- Setting up the Insurer file (VA Fileman Insurer file)

### Input Provider Taxonomy Codes

*What is a Provider Taxonomy Code?*

Each provider you bill for **must** have a specific code assigned to him/her in RPMS. If that code is not entered into RPMS, the entire 837 transaction will be rejected by the insurer. These codes are called Provider Taxonomy codes. For more important information about the Provider Taxonomy Codes, [click here](#) and view slide 4.

*How do I find the right code?*

The codes are published by Washington Publishing Company. To find the most current code list, go to <http://www.wpc-edi.com/codes/taxonomy>. Be sure to go to the drop-down menu on the right under Provider Taxonomy Codes and read through the topics, in particular "How do I use the On-Line list?"

The Office of Information Technology (OIT) will provide the updates to be installed into RPMS under the AUT namespace. This means that the Taxonomy updates will be maintained separately.

For more important information about finding the codes, [click here](#) and view slides 5-10.

Tip
Providers may have more than one Taxonomy code associated to them. When determining what code or codes to associate with a provider, review the requirements of the trading partner with which the code(s) are being used.

*How do I input the code?*

Provider Taxonomy codes need to be added manually into RPMS using VA Fileman and the User Management options in the Kernel Menu. If you do not have access to these options, request help from your site manager/system manager. These codes are located in the PRV segment, piece 4. This is a one-time procedure.

Type of Code	Tips	Where to Input Code
Individual or Group Codes	<ul style="list-style-type: none"> <li>Set up codes for all billable providers, including secondary providers (e.g., RN's, Pharmacists) that your facilities may have on a claim.</li> <li>Start by inputting your most common providers.</li> </ul>	VA Fileman/New Person file
Non-Individual Codes (for your general location)	<ul style="list-style-type: none"> <li>Set up codes for all billing locations.</li> </ul>	VA Fileman/Location file

For more important information about inputting taxonomy codes, [click here](#) and view slides 11-18.

See also [Manually Adding Provider Taxonomy - HIPAA Requirement](#).

*Things to Know*

- Crosswalk: A crosswalk was built into RPMS 3rd Party Billing to alleviate sites from having to populate numerous locations. The patch providing the crosswalk is Provider/Location Taxonomy AUT Patch v98.1, Patch 13.
- Billing and Claims Editor: The Provider and Location Taxonomy codes may be used as soon as they are entered. The user will not see the codes in the claim editor. To view the codes, access the Provider Inquiry (PRTM) option in Table Maintenance.

**Set Up Location files (Third Party Billing Table Maintenance)**

The Location files are set up on a one-time basis. Complete this step for each location that is to be billed. This step provides the physical street address to your claims, as required for the 837.

If you have already been testing the 837 format with other insurers, it is possible that this has already been completed for your site.

Check locally before completing this step.

For more important information about setting up the location file, [click here](#).

### Set up Insurer file (VA Fileman Insurer file)

Set up each insurer in the Insurer file.

- Enter the trading partner's name.
- Enter the trading partner's Associate Operator (AO) control number. This is the insurer's electronic identification. All sites use the same number for an insurer.
- Enter the Electronic Media Claims (EMC) submitter identification. This is the login information (number and password) assigned by a particular insurer to your facility. It will be found in the Companion Guide or will be provided by the insurer. You cannot test the electronic claims submission process without it.

For more information about setting up each insurer file, [click here](#).

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## Populating RPMS for Error-Free Claims


The electronic claims submission process requires precision. If data elements are entered incorrectly, the claim will be rejected.

- If a data element is mandatory, it **must** have data in it.
- Data elements **must** be entered exactly as prescribed.
- There can be no special characters or punctuation.
- Data elements for a patient **must** be entered the same way at every location.

This may be difficult for people who are used to entering data in a certain way.

### Example

Generally, the name of the town is typed this way: **Ft. Defiance** But the period is not allowed on an 837 transaction.

 On the 837 the name of the town must be entered as: **Ft Defiance** or **Fort Defiance**

For more information on common data errors that cause an 837 claim to be rejected, [click here](#).

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## Test Mode

### Levels of Testing

There are two levels of testing. You must pass both levels. For instance, you might pass Level 1 and have the file initially accepted, but you could still fail the Level 2 edits with the insurer. You must continue the testing until you pass Level 2.

#### *Level 1: HIPAA Compliance Testing*

Each site is responsible for making sure that its transactions are compliant with HIPAA mandates. This means that the site must be able to produce and accept HIPAA compliant transactions. Generally, Level 1 testing is conducted with the insurer. However, it can also be conducted using a third-party tool, e.g., Claredi.

There are six types of tests at Level 1.

1. Integrity Testing  
This testing validates the basic syntactical integrity of the EDI file.
2. Implementation Guide Requirements Testing  
This testing involves requirements imposed by the HIPAA 837 Implementation Guide, including validation of data element values specified in the Guide.
3. Balancing Testing  
Balancing verification requires that summary-level data be numerically consistent with corresponding detail-level data, as defined in the HIPAA 837 Implementation Guide.
4. Inter-Segment Situation Testing  
Situation testing validates inter-segment situations specified in the HIPAA 837 Implementation Guide (e.g., for accident claims, an Accident Date must present).
5. External Code Set Testing  
This testing validates code set values for HIPAA mandated codes defined and maintained outside of the HIPAA Implementation Guides. Examples are local Procedure Codes for which states were given waivers, NDC Drug Codes, Claim Adjustment Reason Codes, Claim Status Codes, Claims Status Category Codes, and Remittance Remarks Advice Codes. The last four codes and updates are published by [Washington Publishing Company](#) and OIT updates them.
6. Product Type or Line of Service Testing  
This testing validates specific requirements defined in the HIPAA 837 Implementation Guide for specialized services such as durable medical equipment (DME).

### Level 2: Insurer Testing

Level 2 testing is trading partner-specific. This involves testing the coding and transaction requirements that are required by the insurer but that are not specifically determined by HIPAA. These requirements will be found in the insurer's Companion Guide.

#### Ready to Begin Testing Claims?

- ✓ The required software is installed. (See Newsletter #2)
- ✓ The Trading Partner Agreement and EDI forms are in place. (See Newsletter #2)
- ✓ RPMS set-up is complete and correct. (See above)
- ✓ You have tested for HIPAA compliance. (See above)
- ✓ You have complied with the insurer's requirements in the Companion Guide. (See above)

## The Testing Process

The Billing Office is now ready to batch and submit the 837 for testing.

1. Choose bills for the initial test batch.
  - The bills should include a variety of the visit types that you already bill to the insurer (e.g., Institutional, Professional, and Dental).
  - If appropriate, include a variety of locations.
  - The Companion Guide will tell you how many bills should be included in the test batch. If it doesn't, three of each type is recommended.
  - The filename for a batch cannot be more than 16 characters. Your trading partner's Companion Guide may have naming conventions that the partner wants to use.
2. Check each bill carefully to make sure that it is correctly populated: the mandatory fields are filled in and the data entered adheres to the 837 conventions.
3. Set the EMC Test Indicator to identify the file as a test file. To learn how, see [Test Mode](#).
4. On each claim, change the mode of export. To learn how, see [Test Mode](#).
5. Submit different batches to the insurer, one for each 837 format.
6. Once the claims (3 or more) of one 837 format are approved, export the batch in the usual process via RPMS Pub Directory.
7. Once you submit a batch via FTP or your usual process, e-mail the insurer that a file has been submitted and request verification that they received the file. If you have problems, consult your local or Area IT contact.
8. Wait for a response or error report from the insurer. If you do not hear from the insurer within 24 hours, call your insurer contact to find out the status of the file.
9. If you receive an error report, fixes will be made locally either by the Business Office or by the Patient Registration staff, depending on the error. If you can't figure out how to fix the error, consult with your local or Area IT contact.
10. Once the errors are corrected, resubmit the claims to the insurer.

11. Repeat this process until the claims pass with no errors.
12. After the initial claims go through with no errors, prepare a larger batch (@ 25 claims) of each 837 format and test these claims following steps 2-11.

**NOTE: Reading error reports and making corrections will be addressed in the next newsletter.**

For information on testing and Trailblazers, go to [Trailblazers Medicare Part A:837 Testing and Production Procedures](#) and [Trailblazers Medicare Part B:837 Testing and Production Procedures](#).

### Testing Realities

- Be aware that completing the testing process may take a while, depending on the amount of time your site puts into it. Testing time varies by insurer as well as by the process used and the number of claims that have to be tested.
- If there is a clearinghouse involved, there is another level of preparation and testing to be worked out. It may also be more labor intensive.
- If you have errors in the claims, they will not be paid until they are corrected.
- If your testing involves several locations and/or insurers, there are more possibilities for errors. Monitor each batch submitted and provide timely corrections.

### Testing Tips

- Evaluate your staffing needs before you begin testing. Your staff is probably already busy. Demands on staff time will increase. Anticipate this and assign adequate resources. For example:
  - Cleaning up the patient database may require a massive effort.
  - In the Billing Office, you have a double workload: 1) maintaining the regular claims process so payments continue and 2) creating and submitting test files.
- Be as prepared as you can before you start testing but don't delay testing because you don't think you are prepared. The sooner you jump in, the sooner you will be through it.
- To keep everyone informed of the progress being made in the testing process, set up an e-mail group that includes insurer contacts, OIT contacts, Area contacts, and Service Unit contacts.
- Keep in frequent communication with your insurer contacts.
- The insurer may be willing to provide training on what the plan covers and what needs to be included on the 837.
- Document the process. This will be a teaching tool for you and others. It will also show patterns that you need to address.
- If you need help, turn first to your own IT person. If you can't figure it out locally, follow local procedures to get assistance.
- Submit batches frequently to keep them small. Remember that you will have to correct errors and small batches are more manageable.

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## Production Mode

Once all the test claims are accepted as error free, the insurer will place you in production status. NOTE: You may have to request to go into production. At this point, you will need to:

- Change the "T" to "P" in the Insurer file. This must be done for each insurer at the time you are granted approval for production.
- Change the mode of export on a permanent basis.

For more important information about changing to production mode, [click here](#).

For information on production and Trailblazers, go to [Trailblazers Medicare Part A:837 Testing and Production Procedures](#) and [Trailblazers Medicare Part B:837 Testing and Production Procedures](#).

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## Resources

## Where Are We Now?

IHS tracks the testing status of business transactions. To see the current testing status, [click here](#).

## Summary

This newsletter is one in a series of six on the topic "Electronic Transactions . . . It's Easier Than You Think." Each of the newsletters is associated with a PowerPoint presentation expands on the contents of the newsletter in a format that supports self-paced or group training. Even greater technical detail is presented in two Quick Reference Guides: "Working with the 837 Transaction" and "Working with the 835 Remittance Advice." Electronic versions of these materials are available on the IHS Electronic Transactions website at [www.ihs.gov/AdminMngrResources/HIPAA/index.cfm](http://www.ihs.gov/AdminMngrResources/HIPAA/index.cfm). A training resources binder includes printed copies of these materials and a CD-ROM with electronic copies of the files.



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